Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DAMON LEWIS 9505 RED WILLOW DALLAS, TX 75249	MFDR Tracking #: M4-10-0949-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: PROTECTIVE INSURANCE CO. REP. BOX #: 17	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: A position summary was not submitted with the request.

Principle Documentation:

1. DWC 60 package
2. Prescription Detail
3. Total Amount Sought $195.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Further, the date of service 8/2009 (as indicated on the Table of Disputed Services), was not first sent to the Carrier for reimbursement as required by DWC Rule 133.270. Respondent request that this date of service also be dismissed from Medical Fee Dispute Resolution… This dispute involves medications allegedly paid by the Claimant. On September 1, 2009, Respondent issued a letter to the Claimant denying all requests for medication reimbursements as not medically necessary pursuant to a peer review and designated doctor's report. As all treatment was denied as not medically necessary, this dispute is not proper for Medical Fee Dispute Resolution, and should have been filed with an IRO. Respondent requests that this case be dismissed…"

Principle Documentation:

1. DWC 60 package
2. Letter to Claimant, dated 9/1/09

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Codes	Disputed Service	Amount in Dispute	Amount Due
04/24/09, 05/29/09, 06/24/09, 07/22/09	EOBs not submitted	Out of pocket expenses for prescription medications (Hydrocodone and Alprazolam).	$150.00	$0.00
08/09	EOB not submitted	Out of pocket expenses for prescription Medications.	$ 45.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. The Respondents' response contained a letter, dated September 1, 2009, to the Requestor denying dates of service 04/27/09 through 07/22/09 as not medically necessary.

2. In accordance with 28 TAC Section 133.307(c)(3)(C) and (D) the Requestor has not submitted proof of employee payment and a copy of the denial of reimbursement relevant to the dispute or convincing evidence of the employee's attempt to obtain reimbursement from the carrier for date of service 08/2009; therefore, in accordance with 133.307(e)(3)(I) the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code.

3. This dispute relates to out of pocket expenses for prescription medications with reimbursement subject to the provisions of Rule 134.504.

4. The claimant was sent Form LHL-009 with instructions, along with the Medical Dispute Resolution Rules 133.307 (MDR of Fee Disputes), 133.305 (General Rules) and 133.308 (MDR by Independent Review Organizations) on November 12, 2009.

5. The Division concludes that this dispute was not filed in the form and manner prescribed under Rule 133.308(a). As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.307, §133.308, §134.504

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

Authorized Signature	Auditor III, Medical Fee Dispute Resolution	December 2, 2009 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.